DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 0 4

2. STATE: HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
MEDICAL ASSISTANCE

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/03

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SECTION 1902(V) of the act

7. FEDERAL BUDGET IMPACT:
a. FFY N/A $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SUPPLEMENT 6 TO ATTACHMENT 2.6-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SAME

10. SUBJECT OF AMENDMENT:
STANDARDS FOR OPTIONAL STATE SUPPLEMENTAL PAYMENTS

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Elizabeth Kent

13. TYPED NAME:
Susan M. Chandler

14. TITLE:
Director

15. DATE SUBMITTED:
NOV 27 2002

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 2, 2002

18. DATE APPROVED:
December 17, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

SUPPLEMENT 6 TO
ATTACHMENT 2.6 - A

State HAWAII

Standards for Optional State Supplementary Payments

Payment Category	Administered by		Income Level				Income Disregards
(Reasonable Classification)	Federal	State	Gross		Net		Employed
			1 person	Couple	1 person	Couple	
(1)	(2)		(3)		(4)		(5)
A, B, D IN DOMICILIARY CARE:	X						
- LEVEL I	$552	$521.90	$1,656	N/A	$1,073.90	N/A	
- LEVEL II	$552	$629.90	$1,656	N/A	$1,181.90	N/A	

NOTE: *Gross income, before deductions allowed by SSI, cannot exceed 300% of the FBR.
**Net income, after deductions allowed by SSI, cannot exceed the SSI/SSP payment limit

TN No. 02-004
Supersedes
TN No. 01-012

Approval Date: DEC 17 2002

Effective Date: 01/01/03